Medicaid 1915(c)
Home and Community-Based Services Waiver
for
Individuals With Acquired Brain Injuries

STATE IMPLEMENTATION PLAN

effective
July 1, 2004

Long Term Care Unit
Division of Health Care Financing
Utah Department of Health

Approved by
CMS Region Office VIII
July 2004

STATE OF UTAH
MEDICAID 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVER
for
INDIVIDUALS WITH ACQIRED BRAIN INJURIES

SECTION 1915(c) WAIVER FORMAT

1. The State of Utah requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. ___ Yes b. X No

   If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. ___ 3 years (Initial waiver)

   b. X 5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. X Nursing facility (NF)

   b. ___ Intermediate Care Facility for people with mental retardation (ICF/MR)

   c. ___ Hospital

   d. ___ NF (served in hospital)

   e. ___ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. ___ aged (age 65 and older)

b. X disabled*

*This waiver is limited to persons with disabilities who have established eligibility for state matching funds through the Utah Department of Human Services in accordance with UCA 62A-5.

c. ___ aged and disabled

d. ___ mentally retarded

e. ___ developmentally disabled

f. ___ mentally retarded and developmentally disabled

g. ___ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested in order to impose the following additional targeting restrictions (specify):

a. X Waiver services are limited to the following age groups (specify):

18 years of age and older

b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

i. Acquired brain injury defined as being injury related and neurological in nature, and includes cerebral vascular accident. Acquired brain injury does not include individuals whose primary diagnosis is mental illness, substance abuse, or individuals with deteriorating diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer.

ii. Individual score between 40 and 120 on the Brain Injury Waiver Comprehensive Assessment Form.

iii. This waiver is not available to individuals who have mental retardation or other related conditions as defined in 42 CFR 483.102(b)(3) and 42 CFR 435.1009.

c. ___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by Public Law 100-203 to require active treatment at the level of care of an ICF/MR.

d. ___ Other criteria specified in Appendix C-4.

e. ___ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. X Yes b. ___ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy

a. X Yes b. ___ No c. ___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ___ Yes b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ___ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in appendix B-1 of this request, be included under this waiver:

a. X ABI Support Coordination

b. X Chore Services

c. X Community Living Supports
(see Appendix B-1 & G-2 for defined elements of this category)

d. X Companion Services
(see Appendix B-1 & G-2 for defined elements of this category)

e. X Family Assistance and Supports
(see Appendix B-1 & G-2 for defined elements of this category)

f. X Habilitation, day (Structured Day Program)
(see Appendix B-1 & G-2 for defined elements of this category)

g. X Homemaker Services

h. X Personal Emergency Response System (PERS)
(see Appendix B-1 & G-2 for defined elements of this category)

i. X Respite Care Services (Unskilled)
(see Appendix B-1 & G-2 for defined elements of this category)

j. X Specialized Medical Equipment & Supplies
(see Appendix B-1 & G-2 for defined elements of this category)

k. X Supported Employment Services
(see Appendix B-1 & G-2 for defined elements of this category)

l. X Transportation Services (Non-medical)
(see Appendix B-1 & G-2 for defined elements of this category)

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. A written individual support plan will be developed by qualified individuals for each individual served under this waiver. This individual support plan will describe the

medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written support plan. The individual support plan will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the individual support plan. FFP will not be claimed for waiver services that are not included in the individual written care plan.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. ___ Meals furnished as part of a program of adult day health services.

c. ___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3-meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of the individuals receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for the level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.)

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home and community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the waiver service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the setting(s) indicated in item 2 of this request~~,~~ in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

i. X Yes ii. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that individual support plans are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

19. An effective date of July 1, 2004 is requested.

20. The State contact person for this request is Tonya Keller, who can be reached by telephone at (801) 538-9136.

This document, together with Appendices A through G, and all attachments, constitutes the State of Utah's request for a home and community-based services waiver under section 1915(c) of the

Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensing and certification requirements) will be kept on file at the Medicaid agency.

Signature: /s/.

Print name: Michael Deily.

Title: Director, Division of Health Care Financing.

Amendment Request Date: March 31, 2004.

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APPENDIX A - ADMINISTRATION

APPENDIX A-1: LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

___ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The waiver will be operated by the Department of Human Services, Division of Services for People with Disabilities (DSPD), a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

___ The waiver will be operated by _____, a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

By providing immediate assistance to waiver enrollees with an identified need, the services covered by this waiver, as described below, serve to prevent institutionalization of these individuals. The cost-effectiveness of the covered services is demonstrated in Appendix G.

X **ABI Support Coordination** serves the purpose of: (a) establishing and maintaining the individual in the support system and the Home and Community-Based Services Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver services.

Support Coordination assists individuals to: (a) establish Medicaid financial and categorical eligibility, (b) identify the supports necessary to insure the individual's health and safety, (c) write, coordinate, integrate, and assure the implementation of the individual's support plan, (d) gain access to waiver supports, State Plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source, and (e) develop a personal budget as a component of the individual support plan.

Support Coordination also involves activities to: (f) provide an initial assessment and ongoing reassessment of the individual's level of care determination, (g) facilitate a person-centered plan, (h) review the individual's support plan at such intervals as are specified in appendices D & E of the Waiver Application document, (i) write and update personal social history, (j) provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's support plan, (k) instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, (l) provide discharge planning services up to 90 days immediately prior to the date an individual living in a Nursing Facility is transitioned to the waiver, and (m) provide discharge planning services up to 90 days immediately prior to the date an individual is disenrolled from the waiver.

X **Chore Services** serve the purpose of maintaining a clean, sanitary and safe living environment in the individual's residence.

Chore Services involve heavy household tasks such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

Elements of Chore Services Category: The Chore Services category includes both an agency-based provider model and a self-directed employee model.

Limitations: These services will be provided only in cases where the individual lacks the ability to perform or financially provide for the services, and no other relative, caregiver, landlord, community/volunteer agency, third party payer, or other informal support

system is capable of or responsible to perform or financially provide for the services. In the case of rental property, the responsibility of the landlord, pursuant to the lease arrangement, will be examined prior to any authorization of service.

X **Community Living Supports** serve the purpose of facilitating independence and promoting community integration by assisting an individual to gain or maintain skills necessary to live as independently as possible in the type of community-based housing arrangement the individual chooses, consistent with the outcome for community living defined in the individual's support plan.

Community Living Supports can include up to 24-hour direct care staff support. Actual type, frequency, and duration of direct care staff support, and other community living supports will be defined in the individual's support plan based on the individual's selected housing arrangement and assessed needs. Supports are available to individuals who live alone, with roommates, or with family. Community Living Supports incorporate companion services, which consist of non-medical care, supervision, and socialization, as part of the bundle of services provided. Community Living Supports also include assistance with activities of daily living and instrumental activities of daily living which include assistance with meal preparation, eating, bathing, dressing, and/or personal hygiene as determined by the person's identified needs.

Elements of Community Living Supports Category: The Community Living Supports category includes the elements: (a) congregate residential service, (b) host home service, (c) extended living supports in a congregate setting, and (d) supported living service in a home setting. Community Living Supports also include both an agency-based provider model and a self-directed employee model.

The self-directed employee model requires the enrollee to use a Waiver Personal Services Agent as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model.

Limitations: Payments for residential services are not made for room and board, the cost of facility maintenance, or routine upkeep and improvement.

X **Companion Services** involve non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the individual support plan, and is not purely diversional in nature. Because companion services are included in the bundle of services provided to individuals receiving Community Living Supports, these individuals are not eligible for services under the independent Companion Services category.

Elements of Companion Services Category: The Companion Services category includes both a quarter-hour element for use in cases of incremental services totaling less than six (6) hours per day and a flat sum daily element for services involving six or more hours per day.

X **Family Assistance and Support** serves the purpose of enabling the family member with disability, who so desires, to remain in and be supported in the family home. Family Supports are intended to support both the family member with a disability and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement.

Family Assistance and Support can be provided either in or out of the home to an individual and his/her family. These supports may include provisions to accommodate the individual's disability in accessing supports offered in the community, providing instructions, and supervision and training to the family/ caregiver/ individual in all areas of daily living. The supports may also include other activities that are identified in the individual's support plan as necessary for continued skill development. Skill development supports may include: a) developing interventions to cope with problems or unique situations that may occur within the complexity of the family, b) techniques of behavior supports, c) enrollment in special summer programs, d) social skills development, e) appropriate leisure time activities, and f) instruction and consultation for the individual with disabilities, the parent and/or siblings.

Elements of Family Assistance and Support Category: The Family Assistance and Supports category includes both an agency-based provider model and a self-directed employee model.

In the self-directed employee model, the individual may use an individual age 16 and older as a direct provider of support. The self-directed employee model requires the enrollee to use a Waiver Personal Services Agent as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model.

Limitations: Services and supports provided through the Family Assistance and Support category are intended to accomplish a clearly defined outcome that is outlined in the individual support plan, including the expected duration of the activity and the measures to be used to gauge progress. The activities will not consist solely of companionship or observation of the individual during leisure and other community events.

X **Habilitation, Day (Structured Day Program)** is a program of meaningful supervised activity directed at the development and maintenance of independence and community living skills. Services may take place at home or in a setting separate from the home in which the recipient lives. Services shall include nutritional supervision, health monitoring and recreation as appropriate to the individualized support plan, and transportation to program activities. Services may include group or individualized life skills training that will prepare the individual for community reintegration, including, but

not limited to, attention skills, task completion, problem solving, safety and money management.

Transportation between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) is the responsibility of the Day Habilitation provider when other transportation is not available. Transportation between the individual's place of residence and the site of the habilitation services, or between habilitation sites is covered as a separate waiver service and will not be reimbursed as an element of the Habilitation, Day rate.

Elements of Habilitation, Day Category: The Habilitation, Day category involves a non-site based element in which a variety of settings, including the home, are utilized to develop a meaningful day program specific to the individual's circumstances, and a site-based element in which an individual-specific daily worksheet is used in a structured program such as a workshop or day treatment facility.

Limitations: Habilitation services are not otherwise available through a program funded under the Rehabilitation Act of 1973. Division of Vocational Rehabilitation services are excluded from payment as a waiver service. Non-site based services are not provided exclusively in the home and may not occur solely in the home on any single day.

X **Homemaker Services** serve the purpose of maintaining a clean and sanitary living environment in the individual's residence.

Homemaker Services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for those activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Elements of Homemaker Services Category: The Homemaker Services category includes both an agency-based provider model and a self-directed employee model.

X **Personal Emergency Response System (PERS)** serves the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in an emergency.

Personal Emergency Response System is an electronic device of a type that allows the individual requiring such a system to rapidly secure assistance in the event of an emergency. The device may be any one of a number of such devices but must be connected to a signal response center that is staffed twenty-four hours a day, seven days a week by trained professionals. Reimbursement shall include the rental or purchase, installation, removal, replacement and/or the repair of the system.

Elements of Personal Emergency Response System Category: The Personal Emergency

Response System category includes elements for purchase, for installation and testing, and for an ongoing service fee.

X **Respite Care Services (Unskilled)** serve the purpose of providing coverage and/or relief, on a short-term basis, for those persons who normally provide care in a home setting to an individual who is unable to care for himself or herself.

Respite Care Services includes day and overnight services and may be provided in the following locations:

- X Individual's home or place of residence
- X Facility approved by the State that is not a private residence.
- X Temporary care facilities and overnight camps which meet the standards set by DSPD for the temporary care of people with special needs.
- X Other: As specified in the individual support plan, in the community, which may include the private residence of the individual providing respite care, in which case the individual will meet the standards prescribed by the DSPD Regional Office with whom they contract.

Elements of Respite Care Services Category: The Respite Care Services category includes both an agency-based provider model and a self-directed employee model.

The self-directed employee model requires the enrollee to use a Waiver Personal Services Agent as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model.

Limitations: Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not the person's private residence.

X **Specialized Medical Equipment & Supplies** to include devices, controls, or appliances, specified in the individual support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Elements of Specialized Medical Equipment & Supplies Category: The Specialized Medical Equipment & Supplies category includes elements for purchase and for an ongoing service fee.

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

X **Supported Employment Services** serves the purpose of supporting individuals, based on individual need, to obtain, maintain, or advance in competitive employment in integrated work settings.

Supported Employment can be full or part time and occurs in a work setting where the individual works with individuals without disabilities (not including staff or contracted co-workers paid to support the individual). Supported Employment may occur anytime during a twenty-four hour day and supports are made available in such a way as to assist the individual to achieve competitive employment (compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled). Individuals in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual as indicated in the individual's support plan. An individual may be supported individually or in a group. When appropriate, the agency providing Supported Employment may contract with a co-worker to provide additional support, under the direction of a job coach, as a natural extension of the work day.

Elements of Supported Employment Services Category: The Supported Employment Services category includes an element of routine supported employment in which the participating individual is employed in a competitive work environment specific to the individual's circumstances and an element of enclave employment in which participating individuals are employed in an integrated group setting at a host company or in a self-contained business.

Limitations: Payment will only be made for adaptations, supervision, and training required by an individual as a result of the individual's disability and will not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation will be maintained that supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer or beneficiaries to encourage or subsidize an employer's participation in a supported employment program, payments

that are passed through to a beneficiary of Supported Employment programs, or for payments for vocational training that is not directly related to a beneficiary's Supported Employment program.

X **Transportation Services (Non-medical)** serve the purpose of allowing the individual access to other waiver supports necessary to live an inclusive community life. Individuals receiving services are trained, assisted, and provided opportunities to use regular transportation services available to the general public in their community. If regular transportation services are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

Transportation Supports are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

Elements of Transportation Services Category: The Transportation Services category consists of elements for enrollee/family arranged transportation, for transportation by an agency-based provider, and for a multi-pass for a public transit system.

Limitations: Medicaid payment for transportation under the approved waiver plan is not available through medical transportation, transportation available thru the State plan, transportation that is available at no charge, or as part of administrative expenditures. Additional transportation supports will not be available to community living, day habilitation, or supported employment providers contracted to provide transportation to and from the person's residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the provider.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensing, Regulation, Utah Code Annotated (UCA), and Utah Administrative Code (UAC) are referenced by citation. Standards not addressed under uniform State citation are attached. Home and community-based waiver services for individuals with Acquired Brain Injuries are covered benefits only when delivered through individuals contracted with the State Medicaid Agency as evidenced by a signed Medicaid Provider Agreement or a Self-Directed Services Employer-Employee contract.

For purposes of this appendix, the term Individual Medicaid Provider may be an individual contractor, professional agency, commercial business, or other organization.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
ABI Support Coordination	Individual Medicaid provider contracted to provide ABI Support Coordination.			⌈ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌊ See below
Qualified support coordinators shall possess at least a Bachelors degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a training and testing program approved by the State Medicaid Agency.				

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Chore Services	Individual Medicaid provider contracted to provide Chore Services.		Certified per R539-6-7	⎧ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⎨ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and be able to follow instructions, be physically able to do chores required, and be at least 16 years of age.
Community Living Supports	Individual Medicaid provider contracted to provide Community Living supports.	Licensed Residential Treatment Facility or Licensed Residential Support: R501-2 UAC, R539-6 UAC (4 or more individuals)	Certified per R539-6-7 (3 or less individuals)	⎧ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⎨ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.
Companion Services	Individual Medicaid provider contracted to provide Companion Services.		Certified per R539-6-7	⎧ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⎨ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Family Assistance and Support **(Family Support)**	Individual Medicaid provider contracted to provide Family Assistance and Support.		Certified per R539-6-7	⌈ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌊ Must meet all standards for performance and professional training listed in DSPD policy R539-6-4 concerning this support.
Habilitation, Day **(Structured Day Program)**	Individual Medicaid provider contracted to provide Day Habilitation Services.	Site based: R501-2, UAC R539-6-7, UAC	Non site-based: R539-6-7, UAC	⌈ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌊ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.
Homemaker Services	Individual Medicaid provider contracted to provide Homemaker Services.		Certified per R539-6-7	⌈ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌊ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and be able to follow instructions, be physically able to do chores required, and be at least 16 years of age.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Emergency Response Systems (PERS)	Individual Medicaid provider authorized to provide PERS Services.	Current business license	FCC registration of equipment placed in individual's home	⌠ Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌡ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support.
Respite Care Services (Unskilled)	Individual Medicaid provider contracted to provide Respite Care Services.	Licensed by the State of Utah as a specific category of facility/agency as follows: for Licensed Residential Treatment Facility: 62A-2-101-(18) UCA for Nursing Facility: R432-150, UAC for Assisted Living Facility: R432-270, UAC	Certified per R539-6-7	⌠ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌡ Must meet all standards for performance and professional training listed in DSPD policy R539-6-2 and R539-6-4 concerning this support.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Specialized Medical Equipment/Supplies	Individual Medicaid provider authorized to provide Specialized Medical Equipment & Supplies.	Current business license	Certification per R539-8-9 and R539-8-10, UAC	⌠ Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌡ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support All purchases must be made in accordance with State procurement requirements.
Supported Employment Services	Individual Medicaid provider contracted to provide Supported Employment Services.		Certified per R539-6-7	⌠ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌡ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 & R539-8-3 concerning this support.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Transportation Services (Non-medical)	Individual Medicaid provider contracted to provide Transportation Services.	Licensed public transportation carrier or individual with drivers license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA.		⌈ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ⌉ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and possess a current Utah Drivers License and proof of auto liability insurance in amounts required by state law.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to, State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written individual support plan.

APPENDIX B-3: KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

A. KEYS AMENDMENT ASSURANCE

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. __X__ Low income families with children as described in section 1931 of the Social Security Act.

2. __**X**__ SSI recipients (SSI Criteria States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. __X__ Optional State supplement recipients.

5. __**X**__ Optional categorically needy aged and disabled who have income at (Check one):

   a. __**X**__ 100% of the Federal poverty level (FPL)

   b. ____% Percent of FPL which is lower than 100%.

6. __**X**__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   __**X**__ A. Yes ___ B. No

Check one:

a. **X** The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. ___ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

___ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2) ___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) ___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) ___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) ___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___% which is lower than 100%.

(6) ___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. **X** Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. **X** Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

42 CFR 435.301, 435.308, 435.310, 435.113
1902(a)(10)(A)(i)(III) and 1905(n)
1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and 1902(1)(1)(A) and (B)
1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D)
1902(a)(10)(A)(i)(V) and 1905(m)
1902(e)(5), 1902(e)(6)
1902(a)(10)(A)(ii)(XIII)
1902(a)(10)(ii)(XVIII)

APPENDIX C-2--POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **X** **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C. **X** The following formula is used to determine the needs allowance:

Up to $125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; & a utility cost deduction of $158 for households which have a heating or cooling expense, or $79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.). Total not to exceed the FFP limit.

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F. **X** The amount is determined using the following formula:

A spousal allowance as determined under 1924 (d) of the Act.

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B._X_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. **X** The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f) **X** The following formula is used to determine the needs allowance:

Up to $125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; & a utility cost deduction of $158 for households which have a heating or cooling expense, or $79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.). Total not to exceed the FFP limit.

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX C-3: COORDINATION OF MEDICAID ELIGIBILITY DETERMINATION AND LEVEL OF CARE DETERMINATION

Enrollment in the Home and Community-Based waiver is not permitted prior to the date the Medicaid applicant has been determined to meet eligibility for the Medicaid program, the level of care eligibility defined by the Medicaid program for Nursing Facility admission, and the additional targeting criteria of item 4, page 2.

For purposes of the waiver program, documentation of the eligibility dates is accomplished through completion of the Form 927, Home and Community-Based Waiver Referral Form, including signature by both a Medicaid eligibility worker from the State Support Coordinator. The Form 927 must specify the effective date of applicant's Medicaid eligibility determination and the effective date of the applicant's level of care and targeting criteria eligibility determination and be maintained on file by the appropriate Support Coordinator.

Payment for Home and Community-Based waiver services are not permitted prior to the date the Medicaid applicant has been enrolled into the waiver except in the case of support coordination services involving discharge and transition planning provided to a Nursing Facility resident in the 90-day period immediately preceding his or her first day of admission to the waiver.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1: EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

A. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Social Services Worker, licensed in the State

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_X_ Other (specify):

Qualified ABI Support Coordinator (see provider qualifications, page B-8.)

B. STATE MEDICAID AGENCY OVERSIGHT OF LEVEL OF CARE DETERMINATION

The State Medicaid Agency has an interagency agreement authorizing the Division of Services for People with Disabilities to certify the level of care for waiver applicants and recipients. The ABI support coordinator in the Division of Services for People with Disabilities completes the initial level of care determination. However, final responsibility for oversight of the level of care determination process remains with the single state agency and the State Medicaid Agency retains authority to review level of care determinations made by the Division of Services for People with Disabilities and to make necessary modifications to the determinations.

APPENDIX D-2: REEVALUATIONS OF LEVEL OF CARE

A. FREQUENCY OF REEVALUATIONS

Reevaluations of the level of care required by the participant will take place (at a minimum) according by the following schedule (specify):

___ Every 3 months

___ Every 6 months

X Every 12 months (or more often as needed)

___ Other (specify):

B. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care. (Specify.)

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in Appendix B1 of this document

___ Other (specify):

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

___ "Tickler" file

___ Edits in computer system

_X_ Component part of support coordination

___ Other (specify):

APPENDIX D-3: MAINTENANCE OF RECORDS

A. LOCATION OF RECORDS

1. Record of evaluations and reevaluations of level of care will be maintained in the following locations (check all that apply):

   ___ In the Medicaid agency in its central office

   ___ In the Medicaid agency in district/local offices

   X In the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

   X In the support o coordinator's files for the individuals

   ___ In the files of the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations

   ___ By service providers

   ___ Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this appendix for a minimum period of 3 years.

B. COPIES OF CRITERIA FOR EVALUATION/ASSESSMENT

A written comprehensive assessment instrument that includes elements used in the evaluation and reevaluation of a participant's need for a level of care, shall contain, at a minimum, a broad review of the individual, the individual's current supports and additional services needed.

The *BRAIN INJURY WAIVER INTAKE, SCREENING, AND ASSESSMENT FORM* serves as the standard comprehensive assessment instrument. A copy of the instrument is attached as Attachment A.

The standard comprehensive assessment will be conducted to determine the individual's specific need for services and supports to prevent institutionalization and other services and supports to enhance the individual's ability to achieve the desired level of community integration, adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. The comprehensive assessment will be conducted when a significant change in the waiver client's status occurs. At a minimum, a comprehensive assessment will be conducted every 12 months.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

C. LEVEL OF CARE EVALUATION QUALITY ASSURANCE

The State Medicaid Agency retains final authority for oversight of the level of care evaluation process as set forth in Section IV-G of the interagency agreement between the State Medicaid Agency and the Department of Human Services. The oversight function involves an annual review of the level of care evaluations for a sample of waiver participants representative of the caseload distribution across the program. If the sampling identifies potential level of care systematic problems, an expanded review is initiated by the State Medicaid Agency.

APPENDIX D-4: FREEDOM OF CHOICE AND FAIR HEARING

A. FREEDOM OF CHOICE OF PROGRAM

1. When an individual is determined to be likely to require the level of care specified for this request, the person or the person's legal representative will be:

    a. Informed of any feasible alternatives under the waiver; and

    b. Given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, or who are denied the waiver service(s) of their choice or the waiver provider(s) of their choice.

3. The following are attached to this Appendix:

    a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

    b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

    c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

    d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

B. FREEDOM OF CHOICE DOCUMENTATION

Freedom of choice is documented on the Form 817 (page D-8) and is maintained in the support coordinator's file for the individual. This form describes the agency's procedure(s) for informing an eligible individual or the individual's legal representative of the feasible alternatives available under the waiver and allowing individuals to choose either institutional or home and community-based services.

Freedom of choice procedures

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (NF) or home and community-based care. A copy of the DSPD publication *A GUIDE TO SERVICES FOR PEOPLE WITH DISABILITIES* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including nursing facilities and the HCBS Waiver program, is given to each individual making application for waiver services.

2. The support coordinator will offer the choice of waiver services only if:

    a. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community.

    b. The individual support plan has been agreed to by all parties.

    c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the support coordinator, and the individual has received a copy of the Guide, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the individual support plan. It is, however, the individual's option to choose institutional (NF) care at any time during the period they are in the waiver.

4. The waiver enrollee, and the individual's legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the individual support plan if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the individual's support plan.

HOME AND COMMUNITY-BASED SERVICES WAIVER
LEVEL OF CARE DETERMINATION
ACQUIRED BRAIN INJURY

Region/Office | Data Entry

Individual's Name (Last, First, Middle Initial)

Worker Number

Individual's Data Entry Number

Initials:

Date:

Based on formal assessments, the individual must meet **all** requirements in item 1, and at least two criteria on item 2, to meet the level of care requirements for placement in a nursing facility.

1. Must meet **all** of the following:
   - [ ] Primary condition is not attributable to mental illness.
   - [ ] Cannot be maintained in a less restrictive environment without Home and Community-Based Waiver services.
   - [ ] Documentation of a Brain Injury with a **score between 40 – 120** on the Brain Injury Waiver Comprehensive Assessment Form (Intake, Screening, and Assessment Form—Part II).

   [ ] Brain Injury: _____. Code:_____.

2. and must require care above level of room and board as documented by **at least two** of the following criteria (check all that apply).
   - [ ] Due to the diagnosed medical conditions, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up.
   - [ ] The attending physician had determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility; or
   - [ ] The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting and alternatives have been explored and are not feasible.

I hereby certify that but for the provision of Home and Community-Based Waiver services the individual would require the level of care provided in a nursing facility.

Qualified ABI Waiver Support Coordinator:_____. Date:_____.

Choice of Service: I have been advised that I may choose either Home and Community-Based Waiver services or a nursing facility. I have been informed of alternatives available under the Waiver and I choose:

[ ] Home and Community-Based Waiver services. [ ] Nursing Facility.

Individual's and/or Legal Representative's Signature:_____ Date:_____.

Annual Reviews: I hereby certify that the individual's condition and diagnosis have not changed; therefore, there is a demonstrated need for continuing services under the Home and Community-Based Waiver.

Qualified ABI Waiver Support Coordinator:_____Date:_____.

Qualified ABI Waiver Support Coordinator:_____Date:_____.

Qualified ABI Waiver Support Coordinator:_____Date:_____.

INSTRUCTIONS FOR THE FORM 817

PURPOSE:

The form 817 is an eligibility form used for data entry and documenting an individual's diagnosis and eligibility for Home and Community-Based Waiver Services.

COMPLETING THE FORM:

Individual's Name: Means name under which the individual is open on State data-base.
Individual's Data Entry Number: Means individual identification number from the State data-base.

Level of Care Documentation: This section documents that but for the provision of Home and Community-Based Waiver services, the individual would require the level of care provided in a nursing facility.

> Information regarding the individual's brain injury, and level of functioning must be supported by the assessment documents (medical reports, Brain Injury Waiver Intake, Screening, and Assessment Form and Brain Injury Waiver Comprehensive Assessment form).

Signature Area: Initial signature must be on or before the date that the client enters Home and Community-Based Waiver services. The region staff completing the document must be a qualified ABI support coordinator or the document must be reviewed and co-signed by a supervisor who is a qualified ABI support coordinator.

Choice of Service: Indicate that the individual and/or his legal representative have been advised of his right to choose between Home and Community-Based Waiver services or a nursing facility by checking the service chosen and having the individual and/or his legal representative sign in the space provided.

Annual Reviews: Annually, the qualified ABI support coordinator must review the individual's diagnostic information and eligibility for Home and Community-Based Waiver services. If the diagnostic information or level of care information changes, a new form 817 must be completed. If the diagnostic information or level of care remains the same, the professional signs and dates.

DISPOSITION OF FORM:

Once completed, the individual's diagnostic code for brain injury must be entered into the State database for payment to occur.

Placement in the individual's file: File in Eligibility section.

C. RIGHTS TO A FAIR HEARING DOCUMENTATION

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the waiver support coordinator if the individual is denied a choice of institutional or waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service in accordance with R539-2-5. The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

The waiver individual support plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or denial of services felt to be necessary to prevent institutionalization, the individual or legal representative has the right to appeal the decision to revise the individual support plan. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals applying for or receiving waiver services an opportunity for a hearing upon written request (see A.1. above), if they are:

a. Not given the choice of institutional (NF) care or community-based (waiver) services;

b. Denied the waiver provider(s) of their choice if more than one provider is available to render the service(s);

c. Denied access to waiver services identified as necessary to prevent institutionalization; or

d. Experience a reduction, suspension, or termination in waiver services identified as necessary to prevent institutionalization.

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

HEARING RIGHTS

If you or your legal guardian disagree with any decision, service, or action of the Division of Services for People with Disabilities (Division), you have the right to receive a formal hearing at anytime prior to, during or immediately following the 3 step Division resolution process outlined below. The Division staff will begin the Division resolution process or send your request directly to the appropriate agency for a formal hearing (according to your directions) once your completed Hearing Request form 490S is received at the address listed below.

Step 1 The Division staff explains the regulations on which the action is based and attempts to resolve the disagreement.
Step 2 If resolution of the problem is unsuccessful, the Division staff arranges a region review meeting between you and your legal representative, if any, and the region supervisor and/or region director.
Step 3 If a region review does not resolve the issue, Division staff arrange a Division review meeting between you and your legal representative, if any, the Division director and region director.

At anytime during the Division resolution process you may request that the original form 490s and other required documentation be forwarded to the appropriate hearing office, for a formal hearing before that Department's Hearing Examiner. **You must make your request for resolution and/or a hearing within 30 days of the postmark of this notice. This letter represents such a Division decision or action. If you wish to continue to receive services during the resolution of the concern, you must request resolution within 10 days of the postmark of this notice.** You, your parents, and/or your legal guardian have the right to be represented and/or be accompanied by other individuals at the Division review meetings and the Department hearing. You may be eligible for legal help without charge. Your support coordinator at the Division may suggest where free legal help may be available. It should be noted, that your attorney represents you but does not necessarily represent your parents or legal representative.

To begin the resolution process, fill in and sign the bottom half of this sheet. Tear it off and mail it to:

.

PLACE NAME OF REGION DESIGNEE
AND
REGION ADDRESS HERE

Select A or B: □ (A). I want Division resolution □ (B). I want a formal hearing
I would like services to continue during the resolution/hearing process □ Yes □ No
If "yes" this request for a resolution/hearing is being made within 10 days of postmark of this notice
I am requesting a resolution/hearing because

Please Print the Following:

Name:	**Street Address**	**Date**
Social Security Number	**City, State, Zip**	**Telephone**
Signature of Person and/or Representative		

DIVISION OF HEALTH CARE FINANCING
ADMINISTRATIVE HEARING PROCEDURES

All hearings before the Division of Health Care Financing except as otherwise set forth shall be conducted as a formal hearing.

Advance Notice

1. Each individual who is affected by an adverse action taken by DHCF or its administrative contractor will be given advance notice of such action:

2. A notice must contain:

    a. A statement of the action DHCF or its administrative contractor intends to take;
    b. The date the intended action takes effect;
    c. The reasons for the intended action;
    d. The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;
    e. A statement that the aggrieved person may represent himself or use legal counsel, relative, friend, or other spokesman at the formal hearing; and,
    f. An explanation of the circumstances under which Medicaid coverage or reimbursement will be continued if a formal hearing is timely requested.
    g. DHCF will mail an advance notice at least ten calendar days before the date of the intended action.

Request for Formal Hearing

1. An aggrieved Medicaid applicant/recipient/provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

2. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested.

3. The address for submitting a "Request for Hearing/Agency Action" is as follows:

Division of Health Care Financing
Attention: Formal Hearings
P.O. Box 16580
Salt Lake City, UT 84116-0580

Reinstatement/Continuation of Services

1. DHCF may reinstate services for recipients or suspend any adverse action for recipients/providers if an aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

2. DHCF must reinstate or continue services for recipients or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

    a. Adverse action is taken without giving the ten-day advanced mailed notice to a recipient/provider in all circumstances where such advance notice is required;

    b. In those circumstances where advance notice is not required, the aggrieved person requests a formal hearing within ten calendar days following the date the adverse action notice is mailed; or

    c. DHCF determines that the action resulted from other than the application of federal or state law or policy.

APPENDIX D-5: REVIEW PROTOCOLS FOR WAIVER DISENROLLMENT

The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

1. Voluntary disenrollments are cases in which clients choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. Documentation will be maintained by the Division of Services for People with Disabilities detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which clients are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

    a. Client death;

    b. Client no longer meets financial requirement for Medicaid program eligibility;

    c. Client has moved out of the State of Utah; or

    d. Client whereabouts are unknown.

3. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the Division of Services for People with Disabilities detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process. Notification shall be provided to the Division of Health Care Financing within 30 days after discharge. Documentation will be maintained by the program, detailing the discharge planning activities completed with the client as part of the disenrollment process

4. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver client no longer meets the corresponding institutional level of care requirements, the client's health and safety needs cannot be met by the current program's services and supports, or the client has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a individual support plan that meets minimal safety standards.

5. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

    a. Appropriate movement amongst programs;

    b. Effective utilization of program potential;

    c. Effective discharge and transition planning;

    d. Provision of information, affording clients the opportunity to exercise all rights; and

    e. Program quality assurance/quality improvement measures.

6. The special circumstance disenrollment review process will consist of the following activities:

    a. The waiver support coordination agency recommending disenrollment will compile information to articulate the disenrollment rationale.

    b. The waiver support coordination agency will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

    c. If state-level program management staff concur with the support coordination recommendation, the case will be forwarded to the DHCF for a final decision.

    d. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

    e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

f. The DHCF final disenrollment decision will be communicated to both the support coordination agency and the state-level program management staff in writing.

7. If the disenrollment is approved, the waiver support coordination agency will provide to the individual the required written notification of agency action and right to fair hearing information.

8. The support coordination agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

APPENDIX E – INDIVIDUAL SUPPORT PLAN

APPENDIX E-1: INDIVIDUAL SUPPORT PLAN DEVELOPMENT

1. The following individuals are responsible for the preparation of the individual support plans:

    _____ Registered nurse, licensed to practice in the State

    _____ Licensed practical or Vocational nurse, acting within the scope of practice under State law

    _____ Physician (M.D. or D.O.) licensed to practice in the State

    _____ Social Worker (qualifications attached to this Appendix)

    _____ Support coordination Team consisting of Registered Nurse and Social Services Worker

    X Other (specify):

    ABI Support Coordinator

2. Copies of written individual support plans will be maintained for a minimum period of 3 years. Specify each location where copies of the care plans will be maintained.

    _____ At the Medicaid agency central office

    _____ At the Medicaid agency county/regional offices

    X By the ABI Support Coordinators

    _____ By the agency specified in Appendix A

    _____ Other (specify):

3. The individual support plan is the fundamental tool by which the State will ensure the health and welfare of the participants. As such it will be subject to periodic review and update. The individual support plan development and ongoing review will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

_____ Every 12 months

__X__ Other (specify): The individual support plan should be reviewed as frequently as necessary, with a formal review at least annually, completed during the calendar month in which it is due.

APPENDIX E-2: MEDICAID AGENCY APPROVAL

A. INDIVIDUAL SUPPORT PLAN DEVELOPMENT

The following is a description of the process by which the individual support plan is made subject to the approval of the Medicaid agency:

1. A written individual support plan is developed for each individual who receives Home and Community-Based waiver supports. The support plan describes the type, amount, frequency and duration of services to be furnished and the type of provider who will furnish them. The support plan is developed by the support coordinator in consultation with the individual, the individual's legal representative and others as necessary and appropriate. The support plan constitutes a plan for services, supports and life activities to meet the needs of the individual and prevent institutionalization.

   The State utilizes the Individual Support Plan (ISP) as a means of identifying the assessed needs of the participant and of identifying the array of services that will meet the participants' assessed needs to achieve the desired outcomes. Annual individual budgets are then produced, with sufficient funds allocated to cover the array of services indicated in the ISP. The ISP and the budgets are reviewed and agreed upon by the individual and the support coordinator. The ISP and the budget are changed during the course of the year, as needed, to address participants' changing needs.

   The support coordinator and client then coordinate on an on-going basis throughout the year to review the progress toward the desired intended outcomes, service utilization and ongoing appropriateness of current services, and budget expenditures.

   This ongoing coordination may lead to service utilization patterns that change from one month to the next. This flexibility allows the individual to utilize services in a way that best meets their needs and that is responsive to consumer choice and fluctuations that occur in service need.

   Participants may utilize more services in some months than others, but the array of services identified on the ISP, as a whole, remain at or less than the participants annual budget allocation.

2. The DSPD State Office, through an interagency agreement with the State Medicaid Agency, is delegated first level responsibility to review and approve written support plans as part of its state monitoring responsibility.

3. The State Medicaid Agency retains final authority for oversight and approval of the support planning process as set forth in Section G of the interagency agreement between the State Medicaid Agency and DSPD. The oversight function involves an annual review of a sample of waiver recipient's support plans that is representative of the caseload distribution across the program. If the sampling identifies potential support planning systematic problems, an expanded review is initiated by the State Medicaid Agency.

B. STATUTORY REQUIREMENTS AND COPY OF INDIVIDUAL SUPPORT PLAN

1. The support plan will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service regardless of funding source.

2. Additional mandatory support plan content elements are:

   a. Effective date;

   b. Name of individual receiving waiver services;

   c. Address;

   d. Support Coordinator's name and office location;

   e. List of all waiver supports to be provided to the individual, including support coordination when applicable, and all other services needed by the individual, regardless of funding source;

   f. Documentation of individual's choice of waiver providers and that the individual was advised of hearing rights, if not provided choice;

   g. Documentation that individual was informed of rights in accordance with Division of Services for People with Disabilities policies per R539-2-1 and R539-2-5 and rights to hearing;

   h. Expected start date, amount, frequency and duration of each support;

   i. The type of provider who will furnish each support;

   j. Required experience and skills of individual providers of specified Specialized Support(s);

k. Signatures of individual receiving supports, individual's Support Coordinator, and the individual's legal representative (when applicable);

l. Documentation of the individual's choice of waiver services and waiver providers.

3. The *Division of Services for People with Disabilities Service Plan* serves as the standard individual support plan instrument. A copy of the instrument is on file at the State Medicaid Agency.

C. SUPPORT COORDINATION ENCOUNTERS

To better focus primary attention on providing the specific level of support coordination intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual service plan will be the vehicle through which the level of assessed need for case management/support coordination will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers/support coordinators having specific information about their expected roles and responsibilities on an individualized waiver client basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management/support coordination services, and the ongoing evaluation of progress toward the stated objectives.

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payment are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

B. BILLING PROCESS AND RECORDS RETENTION

1. Following on pages F-4 and F-5 is a description of the billing process used for this waiver. Included is a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

    a. When the client was eligible for Medicaid waiver payment on the data of service;

    b. When the service was included in the approved support plan;

    c. In the case of supported employment or education services included as part of support services, when the client was eligible to receive the services, and the services are not available to the client through a program funded under section(s)(15) and (17) of the Individuals with Disabilities Education Act (IDEA) or section 110 of the Rehabilitation Act of 1973.

        X Yes.

        ___ No. These services are not included in the waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

    X All claims are processed through an approved MMIS.

    ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A, and providers of waiver services for a minimum period of 3 years.

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A client's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, client notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Utah Medical Assistance Program (UMAP). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the client is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted in accordance with the procedures outlined in Appendix E-2. The Medicaid agency reviews a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

3. Prior to the delivery of Medicaid reimbursed supported employment services, the Division of Rehabilitation Services (DRS) must document the individual's ineligibility for DRS services funded under section 110 of the Rehabilitation Act. The support coordinator will obtain written documentation (FORM 58) of the DRS determination prior to authorizing reimbursement for supported employment services under the waiver.

   Prior to the delivery of Medicaid reimbursed educational services, the waiver support coordinator must obtain written documentation that the services are not available to the individual through a program funded under section(s) (16) or (17) of the Individuals with Disabilities Education Act (IDEA) The support coordinator will obtain such documentation prior to authorizing Medicaid reimbursement for educational services under the waiver. (This requirement does not pertain to individuals over the age of 22 who are receiving educational services under the waiver.)

4. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

5. The self-directed employee model requires the enrollee to use a Waiver Personal Services Agent as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Waiver Personal Services Agent is a person or organization that assists waiver enrollees and their representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employer of the enrollees' service workers. Tasks performed by the Waiver Personal Services Agent include documenting service workers' qualifications, collecting service worker time records, preparing payroll for enrollees' service workers, and withholding, filing and depositing federal, state, and local employment taxes.

   Enrollee-employed service workers complete a time sheet for work performed. The enrollee confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Personal Services Agent for processing. The Waiver Personal Services Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service worker for the services documented on the time sheet.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1: COMPOSITE OVERVIEW

A. COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE:

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$26,708	$ 9,995	$29,372	$8,691
2	$26,640	$10,195	$29,916	$8,865
3	$27,366	$10,399	$30,470	$9,042
4	$28,485	$10,607	$31,036	$9,223
5	$28,841	$10,819	$31,613	$9,407

B. FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	140
2	150
3	165
4	186
5	198

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2: FACTOR D

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

LOC: **NF**

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 X 2 ____ 3 ____ 4 ____ 5 ____

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
ABI SUPPORT COORDINATION	Month	140	12	$208.35	$350,028
CHORE SERVICES	15 minute	15	520	$3.08	$24,024
COMMUNITY LIVING SUPPORTS – congregate residential service	Day	6	340	$337.85	$689,214
COMMUNITY SUPPORTED LIVING – host home service	Day	10	340	$78.00	$265,200
COMMUNITY SUPPORTED LIVING - extended living supports in congregate setting	15 minute	15	300	$3.46	$15,570
COMMUNITY SUPPORTED LIVING - supported living in home setting	15 minute	46	3700	$5.11	$869,722
COMMUNITY SUPPORTED LIVING - supported living in home setting, self-directed employee model	15 minute	20	1080	$4.62	$99,792
COMPANION SERVICES	Day	15	300	$72.22	$324,990
COMPANION SERVICES	15 minute	22	900	$3.50	$69,300
FAMILY ASSISTANCE AND SUPPORT – agency-based provider model	15 minute	20	960	$4.62	$88,704
FAMILY ASSISTANCE AND SUPPORT – self-directed employee model	15 minute	10	960	$2.82	$27,072
HABILITATION, DAY (STRUCTURE DAY PROGRAM) – routine service	15 minute	16	1054	$3.23	$54,470
HABILITATION DAY (STRUCTURED DAY PROGRAM) - individualized service	Day	12	200	$134.22	$322,128
HOMEMAKER SERVICES	15 minute	8	650	$3.68	$19,136
PERSONAL EMERGENCY RESPONSE SYSTEM – purchase	Each	1	1	$225.91	$226
PERSONAL EMERGENCY RESPONSE SYSTEM – installation & testing	Each	1	1	$50.00	$50

PERSONAL EMERGENCY RESPONSE SYSTEM – service fee	Month	1	12	$38.85	$466
RESPITE CARE (UNSKILLED) – agency-based provider model	15 minute	4	200	$3.26	$2,608
RESPITE CARE (UNSKILLED) – self-directed employee model	15 minute	13	1950	$3.26	$82,641
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES - purchase	Each	1	1	$10,000.00	$10,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES – service fee	Month	3	12	$300.00	$10,800
SUPPORTED EMPLOYMENT – routine model	15 minute	52	1080	$5.12	$287,539
SUPPORTED EMPLOYMENT – enclave model	15 minute	8	240	$33.49	$64,301
TRANSPORTATION, NON-MEDICAL – personal/family arrangement s	per mile	15	600	$0.36	$3,240
TRANSPORTATION, NON-MEDICAL – agency-based provider	Day	24	240	$7.55	$43,488
TRANSPORATION, NON-MEDICAL – multi-pass, public transit system	Month	30	12	$40.00	$14,400
GRAND TOTAL (sum of Column E):					**$3,739,109**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					**140**
FACTOR D (Divide total by number of recipients):					**$26,708**
AVERAGE LENGTH OF STAY: 334 Days					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 X 3 ___ 4 ___ 5 ____

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
ABI SUPPORT COORDINATION	Month	150	12	$213.02	$383,436
CHORE SERVICES	15 minute	15	520	$3.15	$24,570
COMMUNITY LIVING SUPPORTS – congregate residential service	Day	5	340	$344.61	$585,837
COMMUNITY SUPPORTED LIVING – host home service	Day	11	340	$79.75	$298,265
COMMUNITY SUPPORTED LIVING - extended living supports in congregate setting	15 minute	15	300	$3.54	$15,930
COMMUNITY SUPPORTED LIVING - supported living in home setting	15 minute	45	3700	$5.22	$869,130
COMMUNITY SUPPORTED LIVING - supported living in home setting, self-directed employee model	15 minute	28	1080	$4.72	$142,733
COMPANION SERVICES	Day	18	300	$73.84	$398,736
COMPANION SERVICES	15 minute	22	900	$3.58	$70,884
FAMILY ASSISTANCE AND SUPPORT – agency-based provider model	15 minute	20	960	$4.72	$90,624
FAMILY ASSISTANCE AND SUPPORT – self-directed employee model	15 minute	18	960	$2.88	$49,766
HABILITATION, DAY (STRUCTURE DAY PROGRAM) – routine service	15 minute	16	1054	$3.30	$55,651
HABILITATION DAY (STRUCTURED DAY PROGRAM) - individualized service	Day	15	200	$137.23	$411,690
HOMEMAKER SERVICES	15 minute	10	650	$3.76	$24,440
PERSONAL EMERGENCY RESPONSE SYSTEM - purchase	Each	2	1	$230.97	$462
PERSONAL EMERGENCY RESPONSE SYSTEM – installation & testing	Each	2	1	$51.12	$102

PERSONAL EMERGENCY RESPONSE SYSTEM – service fee	Month	3	12	$39.72	$1,430
RESPITE CARE (UNSKILLED) – agency-based provider model	15 minute	6	200	$3.33	$3,996
RESPITE CARE (UNSKILLED) – self-directed employee model	15 minute	17	1950	$3.33	$110,390
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES - purchase	Each	1	1	$10,000.00	$10,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES – service fee	Month	3	12	$306.72	$11,042
SUPPORTED EMPLOYMENT – routine model	15 minute	54	1080	$5.23	$305,014
SUPPORTED EMPLOYMENT – enclave model	15 minute	8	240	$34.24	$65,741
TRANSPORTATION, NON-MEDICAL – personal/family arrangement s	per mile	20	600	$0.37	$4,440
TRANSPORTATION, NON-MEDICAL – agency-based provider	Day	24	240	$7.72	$44,467
TRANSPORATION, NON-MEDICAL – multi-pass, public transit system	Month	35	12	$40.90	$17,178
GRAND TOTAL (sum of Column E):					**$3,995,954**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					**150**
FACTOR D (Divide total by number of recipients):					**$26,640**
AVERAGE LENGTH OF STAY: 334 Days					

APPENDIX G-2

FACTOR D: LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 X 4 ____ 5 ____

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
ABI SUPPORT COORDINATION	Month	165	12	$217.71	$ 431,066
CHORE SERVICES	15 minute	20	520	$3.22	$33,488
COMMUNITY LIVING SUPPORTS – congregate residential service	Day	6	340	$351.50	$717,060
COMMUNITY SUPPORTED LIVING – host home service	Day	18	340	$81.50	$498,780
COMMUNITY SUPPORTED LIVING - extended living supports in congregate setting	15 minute	17	300	$3.62	$18,462
COMMUNITY SUPPORTED LIVING - supported living in home setting	15 minute	29	3700	$5.34	$572,982
COMMUNITY SUPPORTED LIVING - supported living in home setting, self-directed employee model	15 minute	36	1080	$4.83	$187,790
COMPANION SERVICES	Day	25	300	$75.46	$565,950
COMPANION SERVICES	15 minute	26	900	$3.66	$85,644
FAMILY ASSISTANCE AND SUPPORT – agency-based provider model	15 minute	24	960	$4.83	$111,283
FAMILY ASSISTANCE AND SUPPORT – self-directed employee model	15 minute	28	960	$2.95	$79,296
HABILITATION, DAY (STRUCTURE DAY PROGRAM) – routine service	15 minute	18	1054	$3.38	$64,125
HABILITATION DAY (STRUCTURED DAY PROGRAM) - individualized service	Day	15	200	$140.25	$420,750
HOMEMAKER SERVICES	15 minute	14	650	$3.85	$35,035
PERSONAL EMERGENCY RESPONSE SYSTEM - purchase	Each	3	1	$236.05	$708
PERSONAL EMERGENCY RESPONSE SYSTEM – installation & testing	Each	3	1	$52.25	$157

PERSONAL EMERGENCY RESPONSE SYSTEM – service fee	Month	4	12	$40.59	$1,949
RESPITE CARE (UNSKILLED) – agency-based provider model	15 minute	10	200	$3.41	$6,820
RESPITE CARE (UNSKILLED) – self-directed employee model	15 minute	25	1950	$3.41	$166,237
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES - purchase	Each	1	1	$10,000.00	$10,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES – service fee	Month	4	12	$313.47	$15,047
SUPPORTED EMPLOYMENT – routine model	15 minute	57	1080	$5.35	$329,346
SUPPORTED EMPLOYMENT – enclave model	15 minute	10	240	$34.99	$83,976
TRANSPORTATION, NON-MEDICAL – personal/family arrangement s	per mile	22	600	$0.38	$5,016
TRANSPORTATION, NON-MEDICAL – agency-based provider	Day	30	240	$7.89	$56,808
TRANSPORATION, NON-MEDICAL – multi-pass, public transit system	Month	35	12	$41.80	$17,556
GRAND TOTAL (sum of Column E):					**$4,515,331**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					**165**
FACTOR D (Divide total by number of recipients):					**$27,366**
AVERAGE LENGTH OF STAY: 334 Days					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 X 5 ____

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
ABI SUPPORT COORDINATION	Month	186	12	$222.50	$496,620
CHORE SERVICES	15 minute	17	520	$3.29	$29,084
COMMUNITY LIVING SUPPORTS – congregate residential service	Day	7	340	$358.53	$853,301
COMMUNITY SUPPORTED LIVING – host home service	Day	22	340	$83.30	$623,084
COMMUNITY SUPPORTED LIVING - extended living supports in congregate setting	15 minute	22	300	$3.69	$24,354
COMMUNITY SUPPORTED LIVING - supported living in home setting	15 minute	30	3700	$5.46	$606,060
COMMUNITY SUPPORTED LIVING - supported living in home setting, self-directed employee model	15 minute	45	1080	$4.93	$239,598
COMPANION SERVICES	Day	27	300	$77.12	$624,672
COMPANION SERVICES	15 minute	28	900	$3.74	$94,248
FAMILY ASSISTANCE AND SUPPORT – agency-based provider model	15 minute	27	960	$4.93	$127,786
FAMILY ASSISTANCE AND SUPPORT – self-directed employee model	15 minute	44	960	$3.01	$127,142
HABILITATION, DAY (STRUCTURE DAY PROGRAM) – routine service	15 minute	18	1054	$3.45	$65,453
HABILITATION DAY (STRUCTURED DAY PROGRAM) - individualized service	Day	20	200	$143.33	$573,320
HOMEMAKER SERVICES	15 minute	16	650	$3.93	$40,872
PERSONAL EMERGENCY RESPONSE SYSTEM - purchase	Each	1	1	$241.25	$241
PERSONAL EMERGENCY RESPONSE SYSTEM – installation & testing	Each	1	1	$53.39	$53

PERSONAL EMERGENCY RESPONSE SYSTEM – service fee	Month	5	12	$41.49	$2,489
RESPITE CARE (UNSKILLED) – agency-based provider model	15 minute	15	200	$3.48	$10,440
RESPITE CARE (UNSKILLED) – self-directed employee model	15 minute	35	1950	$3.48	$237,510
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES - purchase	Each	2	1	$10,000.00	$20,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES – service fee	Month	6	12	$320.37	$23,067
SUPPORTED EMPLOYMENT – routine model	15 minute	50	1080	$5.47	$295,380
SUPPORTED EMPLOYMENT – enclave model	15 minute	12	240	$35.76	$102,989
TRANSPORTATION, NON-MEDICAL – personal/family arrangement s	per mile	19	600	$0.38	$4,332
TRANSPORTATION, NON-MEDICAL – agency-based provider	Day	34	240	$8.06	$65,770
TRANSPORATION, NON-MEDICAL – multi-pass, public transit system	Month	20	12	$42.72	$10,253
GRAND TOTAL (sum of Column E):					**$5,298,118**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					**186**
FACTOR D (Divide total by number of recipients):					**$28,485**
AVERAGE LENGTH OF STAY: 334 Days					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 ____ 5 __X__

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
ABI SUPPORT COORDINATION	Month	198	12	$ 227.39	$540,279
CHORE SERVICES	15 minute	18	520	$3.36	$31,450
COMMUNITY LIVING SUPPORTS – congregate residential service	Day	7	340	$365.70	$870,366
COMMUNITY SUPPORTED LIVING – host home service	Day	27	340	$ 85.13	$781,493
COMMUNITY SUPPORTED LIVING - extended living supports in congregate setting	15 minute	22	300	$3.78	$24,948
COMMUNITY SUPPORTED LIVING - supported living in home setting	15 minute	30	3700	$5.58	$619,380
COMMUNITY SUPPORTED LIVING - supported living in home setting, self-directed employee model	15 minute	44	1080	$5.04	$239,501
COMPANION SERVICES	Day	29	300	$78.82	$685,734
COMPANION SERVICES	15 minute	27	900	$3.82	$92,826
FAMILY ASSISTANCE AND SUPPORT – agency-based provider model	15 minute	30	960	$5.04	$145,152
FAMILY ASSISTANCE AND SUPPORT – self-directed employee model	15 minute	44	960	$3.08	$130,099
HABILITATION, DAY (STRUCTURE DAY PROGRAM) – routine service	15 minute	18	1054	$3.53	$66,971
HABILITATION DAY (STRUCTURED DAY PROGRAM) - individualized service	Day	22	200	$146.49	$644,556
HOMEMAKER SERVICES	15 minute	23	650	$4.02	$60,099
PERSONAL EMERGENCY RESPONSE SYSTEM - purchase	Each	2	1	$246.55	$493
PERSONAL EMERGENCY RESPONSE SYSTEM – installation & testing	Each	2	1	$54.57	$109

PERSONAL EMERGENCY RESPONSE SYSTEM – service fee	Month	7	12	$42.40	$3,562
RESPITE CARE (UNSKILLED) – agency-based provider model	15 minute	20	200	$3.56	$14,240
RESPITE CARE (UNSKILLED) – self-directed employee model	15 minute	34	1950	$3.56	$236,028
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES - purchase	Each	2	1	$10,000.00	$20,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES – service fee	Month	8	12	$327.42	$31,432
SUPPORTED EMPLOYMENT – routine model	15 minute	41	1080	$5.59	$247,525
SUPPORTED EMPLOYMENT – enclave model	15 minute	14	240	$36.55	$122,808
TRANSPORTATION, NON-MEDICAL – personal/family arrangement s	per mile	28	600	$0.39	$6,552
TRANSPORTATION, NON-MEDICAL – agency-based provider	Day	40	240	$8.24	$79,104
TRANSPORATION, NON-MEDICAL – multi-pass, public transit system	Month	30	12	$43.66	$15,718
GRAND TOTAL (sum of Column E):					**$5,710,425**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					**198**
FACTOR D (Divide total by number of recipients):					**$ 28,841**
AVERAGE LENGTH OF STAY: 334 Days					

EXPLANATION OF D-CHART ESTIMATES

A. Reimbursement Units of Service for Covered Waiver Services

1. ABI Support Coordination - The ABI Support Coordination covered service is reimbursed as a flat rate monthly unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

2. Chore Services - The Chore Services covered service has an agency-based provider model reimbursed as a 15-minute unit of service and a self-directed employee model reimbursed as a 15-minute unit of service. Each model has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

3. Community Living Supports - The Community Living Supports covered service has five component units of service: (a) congregate residential service as a daily unit, (b) host home service as a daily unit, (c) extended living supports in a congregate setting as a 15-minute unit, (d) supported living in a home setting as a 15-minute unit, and (e) supported living in a home setting, self-directed employee model, as a 15-minute unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

4. Companion Services - The Companion Services covered service is reimbursed as a 15-minute unit of service and as a daily unit of service. Each unit of service has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

5. Family Assistance and Supports - The Family Assistance and Supports covered service has an agency-based provider model reimbursed as a 15-minute unit of service and a self-directed employee model reimbursed as a 15-minute unit of service. Each model has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

6. Habilitation, Day - The Habilitation, Day covered service has a routine service component reimbursed as a 15 minute unit of service and an individualized service component reimbursed as a daily unit of service. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

7. Homemaker Services - The Homemaker Services covered service has an agency-based provider model reimbursed as a 15-minute unit of service and a self-directed employee model reimbursed as a 15-minute unit of service. Each model has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

8. Personal Emergency Response System - The Personal Emergency Response System covered service has three component units of service: (a) purchase as a per item unit, (b) installation and testing as a per item unit, and (c) ongoing

service fee as a monthly unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

9. Respite Care Services - The Respite Care Services covered service has an agency-based provider model reimbursed as a 15-minute unit of service and a self-directed employee model reimbursed as a 15-minute unit of service. Each model has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

10. Specialized Medical Equipment & Supplies - The Specialized Medical Equipment & Supplies covered service has two component units of service: (a) purchase as a per item unit, and (b) ongoing service fee as a monthly unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

11. Supported Employment Services - The Supported Employment covered service has a routine service model reimbursed as a 15-minute unit of service and an enclave model reimbursed as a 15-minute unit of service. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

12. Transportation Services - The Transportation, Non-Medical covered service has three component units of service: (a) personal/family arrangement model as a per mile unit (FTP), (b) agency-based provider model as daily unit (MTP), and (c) multi-pass, public transit system model as a monthly unit (UTA). Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

B. Expenses Covered by Waiver Service Reimbursement Rate

2. The reimbursement rate established by the Medicaid Agency for covered waiver services provided through an agency-based provider model includes a percentage for administrative costs associated with performing employer-related functions and for preparing properly formatted claims.

3. The reimbursement rate established by the Medicaid Agency for covered waiver services provided through a self-directed employee model includes a percentage for administrative costs associated with the required Waiver Personal Services Agent performing employer-related functions and preparing properly formatted claims on behalf of employees employed by waiver enrollees. The percentage for administrative costs is consistent with the State Medicaid Agency's normal percentage for State plan services. Upon receipt of the full Medicaid reimbursement for billed claims, the Waiver Personal Services Agent assures employer-related obligations are covered, extracts the established administrative percentage for services performed, and assures payment of the appropriate amount to the employee for services provided.

APPENDIX G-3: METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4: METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5: FACTOR D'

LOC: **NF**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5: FACTOR D' (cont.)

LOC: **NF**

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 lag reports for years 2 & 3 of waiver #0292-03, which serves a similar target population. The results trended forward to the first year of the renewal period (FY05) is $9,995. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

APPENDIX G-6: FACTOR G

LOC: **NF**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for year ____of waiver #0292-03, which reflect costs for an institutionalized population at this LOC.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

X Other (specify):

The 2004 Utah Legislature adopted legislation granting Medicaid nursing facilities a rate increase for FY05 that when added to the FY03 actual expenditures for NF services (actual factor G) will set the FY05 base at $27,182 (no increase was given in FY04 to NFs). An annual inflation factor of 2.0% is added for each year of waiver years two through five. This establishes the base amount for each fiscal year. Each year $2,190 is then added to the base amount to account for a behaviorally complex add-on rate applied to qualifying nursing facility residents. Nursing facility residents with acquired brain injuries are comparable to the targeted waiver population that consistently qualifies for the behaviorally complex add-on rate.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7: FACTOR G'

LOC: **NF**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7: FACTOR G' (cont.)

LOC: **NF**

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 lag reports for years 2 & 3 of waiver #0292-03, which serves a similar target population. The results trended forward to the first year of the renewal period (FY05) is $8,691. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

APPENDIX G-8: DEMONSTRATION OF COST NEUTRALITY

LOC: **NF**

YEAR 1

FACTOR D:	$26,708		FACTOR G:	$29,372
FACTOR D':	$ 9,995		FACTOR G':	$ 8,691
TOTAL:	$36,703	<	TOTAL:	$38,063

YEAR 2

FACTOR D:	$26,640		FACTOR G:	$29,916
FACTOR D':	$10,195		FACTOR G':	$ 8,865
TOTAL:	$36,835	<	TOTAL:	$38,781

YEAR 3

FACTOR D:	$27,366		FACTOR G:	$30,470
FACTOR D':	$10,399		FACTOR G':	$ 9,042
TOTAL:	$37,765	<	TOTAL:	$39,512

YEAR 4

FACTOR D:	$28,485		FACTOR G:	$31,036
FACTOR D':	$10,607		FACTOR G':	$ 9,223
TOTAL:	$39,092	<	TOTAL:	$40,259

YEAR 5

FACTOR D:	$28,841		FACTOR G:	$31,613
FACTOR D':	$10,819		FACTOR G':	$ 9,407
TOTAL:	$39,660	<	TOTAL:	$41,020

APPENDIX G-9: WAIVER SERVICES PROVIDER REIMBURSEMENT RATE SETTING METHODOLOGIES - MAXIMUM ALLOWABLE RATES

A. DEPARTMENT OF HUMAN SERVICES RESPONSIBILITY TO SET WAIVER RATES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. Since DHS usually sets rates at or close to the statistical mean, DHS also assures compliance with Medicaid payment requirements. Medicaid requires that rates for many services not exceed the prevailing charges. Prevailing charges are described at 42CFR § 405.504 and are set at the 75 percentile. The CFR lists other criteria regarding reasonable cost for Medicaid cost-of-service contracts when prevailing charge regulations do not apply. These are found and described at 42CFR § 405.501 and may be used as applicable.

B. AUTHORITY UNDER STATE DIVISION OF FINANCE RULE 33-3-217

DHS has the authority to set rates under the Utah State Department of Administrative Services (DAS), Division of Finance, Rule 33-3-217. This rule sets forth the parameters for open-ended, rate setting within DHS. Requirements for this rule are listed below.

1. All qualified providers can have a contract (no guarantee of placements), or in other words DHS must have a Request for Proposal (RFP) process that meets purchasing requirements.

2. DHS has a rate setting process that establishes reasonable rates.

3. DHS provides for due process to providers that have complaints.

C. COST PRINCIPLES

When setting rates and establishing budgets for cost of service contracts, DHS uses federal and department cost principles. These are described in the Bureau of Contract Management, Contract Information Manual, found on the DHS web site at http://www.hsofo.state.ut.us/Contract.htm. Additional references are given there for circulars containing the federal cost principles. These are issued by the federal Office of Management and Budget (OMB).

D. RATIONALE

1. The Department of Human Services has opted to provide many services using a fixed rate for multiple providers. This allows DHS the flexibility of using many providers across the state and increasing placement options across the state and within communities. Multiple providers are able to more readily respond to

changing service demands. The DHS Bureau of Contract Management (BCM) has overall responsibility for the rate setting process within DHS. The setting of rates is based on a cooperative process between BCM and each division within DHS. Each division is responsible to determine and define the service code and service components within each code. When a division establishes a new service code, they work with BCM to determine the rate to be set for that service. BCM also reviews rates on an ongoing basis and sets (establishes) a DHS Maximum Allowable Rate (MAR) level or Cap for that rate.

2. Each division determines the actual amount to be paid to providers that is not more than the MAR rate level. Divisions make this determination based on available budget and other considerations. Divisions continue to develop new services and to determine the initial payment rate (provisional rate) for those services. BCM will review the proposed new service code and consult with the division and DHCF on determining an acceptable initial rate for the service. BCM gives authorization for the initial (provisional) rate and forwards a rate request form to finance for input on USSDS and to DCHF for input on MMIS.

E. OVERVIEW OF THE RATE SETTING METHODOLOGY

1. There are several methods DHS uses to reimburse providers of services to DHS clients. The DHS Rate Handbook outlines the procedures for setting rates for DHS providers. These methodologies include the use of: (1) the Request for Proposal (RFP) process for cost-reimbursement contracts, (2) sole source contracts, and (3) rate-based unit-of-service contracts. This statement provides the authority and methodologies used for setting and reviewing the rates paid to providers using rate-based unit-of-service contracts with DHS.

2. DHS rates are set and paid on a prospective basis. This means that rates are set based on the market. Although actual costs may decrease or increase, providers are not expected or allowed to refund or bill for differences between actual current costs and rates. Rates are set based on the current market value of services rendered. This is sometimes referred to as the prevailing charge or rate. The nature and requirements of each of the services are defined by the various Divisions within DHS in accordance with the general description of those services outlined in the RFP and contract. Determination of current market value of services is determined by surveying current providers of such services to determine charges for those services or, in the alternate, the actual cost to provide services is used to set rates in lieu of market charges.

3. When data show the market value of services to be tightly clustered among various service providers, statistical measures of central tendency (e.g., mean, median, mode, and/or weighted average) are used. This establishes the most equitable rate that will assure a sufficient supply of service providers and concurrently pay a fair market rate. Measures of central tendency are best applied when data are clustered or normally distributed. When market conditions do not validate these assumptions, other measures will be allowed for use in setting rates

for services including cost accounting measurements and/or those commonly used under Medicare or Medicaid programs. This also applies to rates receiving Medicaid reimbursements.

4. To insure the greatest possible integrity of data supplied by providers, the staff from BCM or the DHS Bureau of Internal Review and Audit may audit data. In addition, non-representative (outlier) survey data may also be dropped from the survey if it is deemed to unfairly bias the results. An example of this would be a small service provider with exceptionally high or low rates that are not representative of the industry and market at large.

F. RATE SETTING METHODS

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Because DHS provides services using various funding sources, including Title XIX, Title XX, Title IV-E among others, adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

   This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

   The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

G. DATA VALIDATION

The Utah Department of Human Services strives to utilize the most accurate information in the rate setting process. DHS uses various methods to validate data used in setting rates; these include both internal and external statistical and accounting tests. The specific methods used are determined by the type of data collected (i.e., from Cost Surveys, Market Surveys, Comparative Analysis, etc.), historical reliability of data sources and demands on staff. The type of tests used are based on the nature of the rate being set. Various methods of validation are explained in the DHS Rate Handbook.

H. COST OF LIVING ADJUSTMENTS (COLA'S)

1. Cost of Living Adjustments (COLA's) to the DHS MAR rate level are made annually, effective with the beginning of each state fiscal year. In general, changes in the twelve month period ending in June (base period) are reflected in an adjustment for the state fiscal year beginning twelve months later (effective date). This interim period is used to collect data from the base period, as it becomes available. The COLA adjustment is scheduled to be completed by the end of the calendar year to allow COLA information to be used in planning for the upcoming state fiscal year.

2. Changes in the MAR rates are based on changes in the cost of living as determined by broad based cost of living indices such as the Consumer Price Index (CPI-u) as published by the U.S. Department of Labor, or more representative local indices such as the Department of Workforce Services index of average Utah wages. The cost of living allowance is calculated by determining the percentage change in the index (or indices) and then applying that percentage change to the rate or rate components of established MAR rates. The MAR rates

revisions are scheduled to be completed and published prior to the start of each state fiscal year.

3. COLA changes to a MAR are likely to be different from legislative rate changes funded in Division budgets. Legislative funding adjustments to Division rates are usually budget constrained and reflect a political perspective and may not be related to actual cost changes in rate components.

I. SUPPORT COORDINATION SERVICE MONTHLY RATE

1. The Support Coordination covered waiver service provider rate is calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR for waiver Support Coordination.

2. Support coordination activities covered by the MAR must be consistent with the definition of Support Coordination contained in Appendix B-1, and the Medicaid Home and Community-Based Services for Individuals with Development Disabilities or Mental Retardation provider manual.

3. Allowable Cost Centers

    a. Annual non-supervisory support coordination labor costs.

    b. Annual non-supervisory support coordination non-labor costs.

    c. Annual first line supervisory employee labor costs.

    d. Annual first line supervisory employee non-labor costs.

    e. Administrative costs associated with provision of support coordination service.

4. Support Coordination MAR Formula

$$\text{Monthly per client rate} = \frac{[(a + b + c + d + e) / (\#\ \text{clients receiving spt. coord.}]}{12\ \text{months}}$$

ATTACHMENT A

Brain Injury Waiver Intake, Screening, and Assessment Form

(Copy on file at the offices of the State Medicaid Agency)

ATTACHMENT B

Division of Services for People with Disabilities Individual Support Plan

(Copy on file at the offices of the State Medicaid Agency)